

DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch

300 South Spring Street, South Tower

Los Angeles, CA 90013

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(213) 897-8921

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CCB-002 B

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**AUTO BODY REPAIR SHOP REPORT FORM**

Name of Automobile Body Repair Shop:	Business Phone:
Address:	Name of Reporting Person:
City : State: ZIP:	Position:

1. Complete name of insurance company involved :
2. Are you reporting a denial in an insurer's Direct Repair Program? Yes ___ No ___ If Yes, Skip to Question 8.
3. Type of Insurance: AUTO
4. Name and Address of the policyholder/claimant/customer:
5. Policy identification number:
6. Claim number:
7. Date loss occurred or began:
8. Name of Adjuster or Insurance Company Representative:
9. Have you reported this to any other governmental agency? Yes ___ No ___ <i>If yes, Please give the</i> <i>Name of the Agency: _____ File number, if known: _____</i>
10. Have you previously written to the California Department of Insurance about this matter? Yes ___ No ___ File number (if available) _____ Date submitted _____

10. Briefly, describe the details of the transaction and provide any documentation to support your allegations.

Signature

Date